

STATE GROUP INSURANCE PROGRAM



State of Tennessee

State & Higher Education Employees

March 2002

INSURANCE HANDBOOK

What Is This Information and Why Do I Need It?

PPO – A health insurance option where participants choose a network provider or a non-network provider. A network provider accepts a pre-negotiated fee. The participant is responsible for a percentage of the maximum allowable charge and an annual deductible. When a patient utilizes a non-network provider, care is paid at a percentage of the maximum allowable charge and charges above the maximum allowable are the patient's responsibility. Annual out-of-pocket maximums apply.

HMO – A health insurance option where care is coordinated through a primary care physician. No benefits, other than approved emergency or urgent care, are paid apart from the HMO's network. Copayments are paid each time services are received. There are no deductibles.

POS – A health insurance option where participants use in-network providers who have agreed to accept a fixed copayment. The delivery of health care services must be coordinated by the participant's primary care physician. Use of out-of-network providers is covered at a percentage of the maximum allowable charge. Charges above the maximum allowable amount are the patient's responsibility. There are no deductibles or out-of-pocket maximums if you use in-network providers.

This *Insurance Handbook* has been provided to help you understand what insurance options are available to you. Health insurance is one of your most valuable employee benefits. Familiarize yourself with topics in this book and recognize your responsibility regarding eligibility and enrollment requirements.

If you meet the eligibility requirements listed on page 5, you will have the following options:

- Preferred Provider Organization (PPO) Health Option
- Point of Service (POS) Health Options *
- Health Maintenance Organizations (HMO) Health Options *
- Optional Dental Insurance
- Optional Special Accident Insurance
- Optional Universal Life Insurance
- Optional Term Life Insurance

*Based on your county of residence or work, you may have the option of choosing coverage through a Point of Service (POS) or Health Maintenance Organization (HMO).

Regardless of which option you select, the Eligibility section of this handbook applies to you. All health and dental coverages have their own member handbooks to explain their benefits. You may obtain a copy of these books from your agency insurance preparer, the person in your department or facility designated to handle insurance matters.

Every full-time employee and certain former employees, such as retirees, may be eligible for health insurance coverage through the state's group insurance program. The Division of Insurance Administration within the Department of Finance and Administration is responsible for administering and/or overseeing all components of the group insurance coverage. The healthcare options are self-insured which means claims are paid from funds controlled by the state which consists of employee premiums and the state's contributions.

Two other groups of employers are also eligible to provide health coverage for their employees and retirees through the state's group insurance program. Local education agencies (K-12 school systems) and local government agencies that elect to participate also provide coverage through separate self-insured healthcare options.

Any changes in premiums or benefits will be communicated through a participant newsletter, *Your Health Network*, mailed quarterly to your home. It is important to maintain your correct address with your insurance preparer at all times.

Words or phrases that may be unfamiliar to you, and are not explained in the text, are defined in the side margin. We hope you will find this information helpful, useful and easy to understand. Please contact the Division of Insurance Administration's communications office if you have comments or suggestions related to this publication or if you require this publication in an alternative format.

Who Governs the Group Insurance Program?

The PPO, POS and HMO benefits and premiums are set by the State Insurance Committee. Members are:

- Commissioner of Finance and Administration (Chairman)
- Comptroller of the Treasury
- Commissioner of Commerce and Insurance
- Commissioner of Personnel
- State Treasurer
- Two members elected by popular vote of general state employees
- One higher education member selected under procedure established by the Tennessee Higher Education Commission
- One representative from the Tennessee State Employees Association selected by its Board of Directors

The State Insurance Committee is authorized to (1) change or end any coverage offered through the state's group insurance program, (2) change or discontinue benefits, (3) establish premiums, and (4) change the rules for eligibility at any time, for any reason.

A Quick Reference

Your insurance preparer is the person designated in your department or facility to handle insurance matters. He/she is available to answer your benefit questions and can provide you with any necessary forms or insurance booklets. Write his/her name in the space below so you can find it easily.

My insurance preparer's name is: _____

Phone number: _____

Telephone Numbers You May Need

Division of Insurance Administration

1300 William R. Snodgrass Tennessee Tower
312 Eighth Avenue North
Nashville, TN 37243-0295

615-741-3590
1-800-253-9981
(8:00-4:30 central time, M-F)

Tennessee Consolidated Retirement System (TCRS)

Insurance Section

10th Floor, Andrew Jackson Building
500 Deaderick Street
Nashville, TN 37243

1-877-681-0155
(8:00-4:30 central time, M-F)

Flexible Benefits

(Excluding higher education employees)
10th Floor, Andrew Jackson Building
500 Deaderick Street
Nashville, TN 37243-0228

615-741-3131
(8:00-4:30 central time, M-F)

For member services telephone numbers, contact your department insurance preparer or refer to the back of your insurance identification card.

Website

Please visit the Division of Insurance Administration's website which is located at www.state.tn.us/finance/ins/ for the most up-to-date information regarding the insurance program. Most forms and publications mentioned in this handbook can be obtained from the site and links to the various health insurance vendor's websites are also provided.

Is TennCare Related to My Benefits?

No. TennCare is the managed care program that replaced Medicaid in 1994. It is not the state's medical plan and is not funded with your premiums. For further information about TennCare, call 615-741-4800 or 1-800-669-1851, 8:00-4:30 central time, M-F. Should you be covered by TennCare and lose coverage, you may be eligible for state coverage if you apply within 60 days of the date coverage is lost.

Who's Eligible?

- Full-time employees regularly scheduled to work 30 hours per week
- Seasonal or part-time employees with 24 months of service and certified by their appointing authority to work at least 1,450 hours per fiscal year, (July–June)

Coverage Available

- PPO, POS and HMO healthcare options, if available in your area — all health coverages include basic term life insurance and basic special accident insurance with amounts based on age and salary
- Optional term life insurance
- Optional universal life insurance
- Optional special accident insurance
- Optional dental insurance

How Do I Pay for Coverage?

The insurance premiums deducted from the paycheck you receive at the end of each month include payment for your health, dental and life insurance coverages. These deductions pay for the following month's coverage. Premiums are not prorated. Your insurance preparer can provide the premiums for these coverages.

The state also contributes a portion of your health insurance premium if you are in a positive pay status or on approved family medical leave. If approved for workers compensation and receiving lost time pay, the state pays the entire health insurance premium.

The state pays the full cost of providing basic term life insurance and basic special accident insurance if you are enrolled in a health insurance program based on the following schedule.

Age of employee	Basic Term Life	Basic Special Accident
Under 65	\$ 20,000	\$ 40,000
65-69	\$ 13,000	\$ 26,000
70-74	\$ 9,000	\$ 18,000
75 and over	\$ 6,000	\$ 12,000

The **total amount** of your basic term life and basic special accident coverage depends on your age and salary. Your insurance preparer can provide you with total amount of coverage and premium. You are responsible for the cost of additional insurance beyond the amount provided by the state and listed above. The life insurance premium is combined with your health premium and cannot be separated.

What Types of Coverage Are Available?

- Single: Covers employee only
- Family: Covers employee, spouse and all eligible dependent children
- Split/Single Split: This coverage applies when a husband and wife are both employed by the state and will ensure that each employee receives the maximum amount of basic life insurance available to them. If there are dependent children, one employee will enroll in split and cover himself or herself and the dependent children; the other employee will enroll in single split and cover only himself or herself. If there are no dependent children to be covered, each employee will enroll in single split coverage.

A newly hired employee can elect coverage for his/her spouse as a dependent when that spouse is an eligible, state employee who originally declined coverage. This employee will always have dependent status unless he or she is eligible and meets the requirements for the special enrollment provisions listed on page 11 or is approved through late applicant medical underwriting.

When Does Coverage Begin?

Positive Pay Status –
Receiving monetary compensation even if the employee is not actually performing the normal duties of their job. This is related to annual leave, sick leave, compensatory leave and any other type of approved leave with pay.

You have from the first day of employment through the last day of the first full calendar month worked to submit your enrollment form. Coverage begins on the first day of the month after you have been employed one full calendar month or you can choose to have your coverage begin on the first of the subsequent month. You must be in a positive pay status on the day your coverage is scheduled to begin. If you fail to enroll by the end of your enrollment period, you will only be eligible by satisfying one of the special enrollment provisions on page 11 or by qualifying under the late applicant medical underwriting process.

A dependent's coverage is effective on the same date as yours unless newly acquired. Newly acquired dependents will become effective on the date they were acquired if you are in the appropriate type of coverage. You may also choose to have coverage effective the first day of the following month.

Coverage for an adopted child begins when appropriate documentation reflecting legal obligation of support of such child is submitted to your insurance preparer. See complete definition of dependents on page 8.

Part-time employees or those in an emergency appointment type will be effective the first day of the month after attaining full-time status if you have completed one full calendar month of employment. You may also choose the subsequent month for coverage to become effective.

You will receive an identification card at your home address within four weeks after the effective date of your coverage. You may call the health provider to request additional cards.

PPO and POS Pre-Existing Condition Clause

Pre-existing condition shall mean a condition for which a covered person received treatment or advice during the six-month period immediately prior to coverage with the state's plan. The healthcare options that apply a pre-existing condition clause are the Preferred Provider Organization (PPO) and the Point of Service (POS). The HMOs do not have pre-existing condition requirements for their enrollees.

The pre-existing condition clause does not apply to pregnancy, newborns or adopted children or children placed for adoption. Also, if you are enrolling (as a new hire) or transferring during the annual enrollment transfer period and have had health coverage without a 63-day lapse between prior health coverage, the six-month pre-existing condition clause will be waived.

Employees and dependents who did not have previous health coverage, or if the prior coverage had not been in effect for more than 63 days, will be required to satisfy the six-month pre-existing condition requirement. Treatments for conditions determined to be pre-existing shall not be considered eligible expenses until coverage has been in force for six months.

Newly hired eligible employees and their dependents will be required to furnish a Certificate of Coverage letter (letter on former employer or insurance carrier letterhead) stating they had prior coverage, the names of participants enrolled and the date the coverage terminated. This letter should be provided to the insurance preparer and is required in order to be exempt from the pre-existing requirements. There cannot be a lapse of coverage longer than 63 days. If the newly hired employee does not have the letter when first enrolled, they may provide the letter at a later date and the insurance preparer can change their coverage to reflect that pre-existing should not apply.

What Are the Distinguishing Features of Each Healthcare Option?

Preferred Provider Organization (PPO)

- Statewide network
- Annual deductible
- Prescription drug copays
- Separate out-of-pocket maximums
- Wider choice of doctors
- Pre-existing conditions will apply if you had no prior coverage
- Benefits are paid whether in-network or out-of-network (percentages vary)

Point of Service (POS)

- Must live or work in service areas
- Must choose Primary Care Physician (PCP) per covered family member
- Co-payment for in-network or out-of-network benefits
- Deductibles apply when using in-network physicians with no referral by PCP
- Deductibles apply when using out-of-network physicians

Health Maintenance Organization (HMO)

- Must live or work in service areas
- Must choose Primary Care Physician (PCP) per covered family member
- Co-payments for physician office visits, prescriptions and hospital admissions
- No deductibles

Your insurance preparer can provide you with a comparison of the state-sponsored insurance programs and a member handbook from each provider describing benefits.

What If I Need to Change My Coverage?

To make a change in your coverage (add or terminate a dependent, etc.), contact your insurance preparer and request an enrollment/change application. Return the completed form to your preparer. The eligibility requirements for dependents listed on pages 8–9 apply.

What Dependents Are Eligible?

- Your spouse (legally married)
- Natural or adopted children (regardless of where they live)
- Stepchildren, if you or your spouse has legal or joint custody or shared parenting
- Children living in the home for whom you are the legal guardian
- Any dependent child living in your home for 12 months a year who is dependent upon you for support and maintenance as evidenced by being claimed as a dependent on your federal income taxes
- Adopted children, in connection with any placement for adoption of a child with any person, means the assumption of a legal obligation of total or partial support of a child in anticipation of adoption — the obligation may be determined by court records, federal income tax records or other appropriate documentation as determined by the Insurance Committee or its representative

Should a change in your dependent's eligibility status occur, notify your insurance preparer to terminate coverage.

All dependents must be listed by name on the appropriate enrollment/change application. Benefits are not provided for dependents not listed on this form. A dependent can only be covered once within the same plan, but can be covered under two separate plans (State, Local Education or Local Government).

Full-time Student – One who is registered for at least the number of credit hours that the institution requires in its definition of full-time student status and who attends classes for two of three semesters or three of four quarters in any 12-month period.

Unmarried dependent children are eligible for coverage through the last day of the month of their 24th birthday. Dependent children between the ages of 19 and 24 must be claimed on your income tax or be a full-time student. Proof of a dependent's eligibility may be required.

Incapacitated children (mentally or physically disabled and incapable of earning a living) may continue health or dental, if applicable, coverage beyond age 24 as long as the incapacity existed before their 24th birthday and they were already insured under the state's group insurance program. The child must meet the requirements for dependent eligibility previously listed. **A request for extended coverage must be provided to the Division of Insurance Administration within 90 days of the dependent's 24th birthday.** Additional proof may be required periodically. Approval of the incapacitation request is determined by the claims administrator for your health insurance company. Coverage will not continue and will not be reinstated once the child is no longer incapacitated.

What Dependents Are Not Eligible?

- Ex-spouse (even if court ordered)
- Married children, regardless of age
- Parents of the employee or spouse
- Foster children
- Children in the armed forces on a full-time basis
- Children over age 24 (unless they meet qualifications for incapacitation)
- Live-in companions who are not legally married to the employee

How Do I Add Dependents to My Coverage?

An enrollment/change application should be completed within 60 days of the date a dependent is acquired. The "acquire date" is the date of birth, marriage, change of student status, or, in case of adoption, the legal obligation and support of such child. Changes in type of coverage (single to family) are effective on the first day of the month in which the dependent was acquired or, if requested, the first of the following month. If you maintained family coverage on the date the dependent was acquired, the effective date may be retroactive to the dependent's acquire date even if beyond the 60 day enrollment period.

An employee's child named under a qualified medical support order may be added within 60 days of the court order, if a court so stipulates. If covering out-of-state dependents, you must be enrolled in the Preferred Provider Organization (PPO).

If you have single coverage and do not notify your insurance preparer within 60 days of acquiring a dependent, the new dependent can only enroll if they meet one of the special enrollment provisions listed on page 11 or by qualifying through the late applicant medical underwriting process.

If dependents are added while you are on single coverage, you must immediately transfer to split or family coverage. This change in type of coverage is also retroactive and you must pay for family coverage for the entire month in which the dependent is insured. ***If the dependent becomes ineligible, it is your responsibility to notify your insurance preparer.*** Refunds for any overpayments will be limited to three months from the date of notification to the Division of Insurance Administration.

How Do I Terminate a Dependent's Coverage?

To remove a dependent from your coverage, complete an enrollment/change application and return it to your insurance preparer. (Check with your insurance preparer to make sure your dependent is no longer eligible for coverage.) When you request cancellation, a dependent's coverage will terminate on the last day of the month in which the form is signed. In the case of ineligibility, the dependent is covered until midnight on the last day of the month that the ineligibility occurs. For adopted children, coverage terminates upon the termination of legal obligation. ***All claims paid for ineligible dependents will be recovered. As the employee, you are responsible for reimbursing the plan for incorrect claims payments.***

Flexible Benefits – Please check with your personnel office before transferring to single coverage or terminating your coverage to see if this has any impact on your flexible benefits program.

You can change your type of coverage by completing an enrollment/change application. Keep in mind that deleting a dependent may make you ineligible for family coverage. Refunds for premium overpayments will be issued for up to three months from the date of notification to the Division of Insurance Administration.

To verify claim payments are paid only for eligible dependents, aged 19–24, the health insurance vendors are required by the state to request annually a verification form ***signed by the employee.*** Claims cannot be paid until the form is returned to the vendor.

The Division of Insurance Administration reserves the right to request documented proof of eligibility of dependents. Failure to provide the requested proof will result in suspension of the dependent's coverage until such proof is provided.

What If I Don't Enroll in Health Coverage When First Eligible?

If you do not elect coverage for yourself and/or your dependents when first eligible (see page 6) and you later decide to enroll, you and/or your dependents will be considered late applicants. ***You are encouraged to apply for health insurance when you are first employed rather than risk the possibility of being unable to obtain coverage as a late applicant.*** If approved through either of the following options, the enrollment will be for health coverage only. You may enroll in dental or optional life coverage(s) during the annual enrollment transfer period.

Special Enrollment Provisions

The federal law, Health Insurance Portability Accountability Act (HIPAA) allows employees and dependents to enroll under certain conditions. Exceptions will also be made for eligible employees or dependents if they lose their health coverage offered through the employer of the employee's spouse/ex-spouse. The required documentation must be submitted to the Division of Insurance Administration and coverage applied for within 60 days of loss of health coverage.

Employee NOT currently enrolled acquires a new eligible dependent (spouse, newborn or adoptee)

- Copy of the birth certificate, marriage certificate or adoption documents

Death

- Copy of death certificate and written documentation from the employer on company letterhead providing names of covered participants and date coverage ended

Divorce

- Copy of the signed divorce decree and written documentation from the employer on company letterhead providing names of covered participants, date coverage ended and the reason why coverage ended

Legal Separation

- Copy of the agreed order of legal separation and written documentation from the employer on company letterhead providing the names of covered participants, date coverage ended and the reason why coverage ended

Loss of Eligibility (this does not include a loss due to failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause)

- Written documentation from the insurance company on company letterhead providing names of covered participants, date coverage ended and the reason for the loss of eligibility

Loss of TennCare (this does not include a loss due to failure of the employee or dependent to pay premiums on a timely basis)

- Certificate of coverage from TennCare stating that coverage has been or will be terminated

Termination of Employment (voluntary and non-voluntary)

- Written documentation from the employer on company letterhead providing names of covered participants, date coverage ended and the reason why coverage ended

The reduction in the number of hours that caused loss of eligibility

- Written documentation from the employer on company letterhead providing names of covered participants, date coverage ended and the reason why coverage ended

Employer's discontinuation of contributions to the spouse's insurance coverage (total contribution not partial)

- Written documentation from the employer on company letterhead providing names of covered participants and verifying the employer's discontinuation of total contribution toward health insurance coverage

The effective date of coverage for a participant approved through a special enrollment provision is either (1) the first of the month in which other coverage was lost, if other coverage was lost in the middle of the month; (2) the first of the month following loss of other coverage if other coverage was lost at the end of the month; (3) the first of the month or subsequent month following approval by the Division of Insurance Administration; (4) the day on which the event occurred, if enrollment is waived due to marriage, birth, adoption or placement for adoption; (5) the first of the month following the 60-day period.

Medical Underwriting

If you or your dependents do not enroll during your eligibility period and do not qualify under a special enrollment provision of HIPAA, you may apply for health coverage by means of a health care evaluation application on yourself and every eligible dependent. The cost of the evaluation, along with the designated application fee is your responsibility. The application will be evaluated through the medical underwriting process for approval/disapproval and you will be notified by letter of the underwriter's decision. The employee (head of contract) must be approved or already participating in the plan before any dependents can be added for coverage. You may apply for coverage as many times as you wish should your medical condition change by submitting a new application and paying the required non-refundable application fee. Declined applications cannot be appealed through the plan's appeal process.

The effective date of coverage shall be the first of the month or subsequent month following the date of the approval letter, or the first of the month following the 60-day period after the approval letter.

Annual Enrollment Transfer Period

During the fall of each year you have the opportunity to transfer your existing state group health insurance coverage if you are currently enrolled. The options are the PPO, POS or an HMO if offered in your area. To transfer to the POS or HMO, you must live or work in the service area. Benefit packets are mailed to your home address and you should review this information carefully to make the correct decision for you and your family. If you decide to transfer to another healthcare option, coverage will be effective on the following January 1, and you must remain enrolled in that healthcare option until the next year unless you move outside the HMO or POS service area. ***This is not an open enrollment period.***

You may also enroll in the optional special accident insurance, enroll in or transfer dental options and enroll in, increase or decrease optional term or universal life coverage. To enroll in optional term or optional universal life, you must answer health questions.

How Do I Terminate Coverage?

If you wish to terminate insurance coverage, you must

- Contact your insurance preparer and complete an enrollment/change application
- Return the completed form to your insurance preparer ***before*** the day the termination is to be effective

A dependent's insurance will be canceled on the last day of the month when he/she becomes ineligible for coverage. It is your responsibility to notify your agency's insurance preparer if your dependent no longer meets the dependent eligibility rules on page 8.

When canceled, insurance coverage ends at midnight on the last day of the month for which you paid your premium. All forms must be completed by the last day of the month to terminate coverage for the following month. For example, if you do not want coverage for the month of December, you must cancel the coverage in writing by the end of November. You cannot cancel coverage for the month of December once the month begins. ***If you are a state employee and are enrolled in the Flexible Benefits Program, check with your personnel office before canceling coverage.***

Any insurance continued for an ***incapacitated dependent child*** ends when he/she is no longer incapacitated, or at the end of the 31-day period after any requested proof is not furnished.

In the event of an employee's death, insured dependents may continue health coverage for six months at no cost, as long as they remain eligible. After this period, covered dependents may be eligible to continue coverage through COBRA (see page 14) or convert to a private direct payment plan with the healthcare provider. The conversion policies offered to employees by the providers may vary a great deal from present coverage. Differences may be the amount of coverage provided, age limitations on dependents and premium costs. Conversion policies are not administered through the State of Tennessee and must be paid on a direct-pay basis to the provider.

What If We Have Other Insurance?

If you are covered under more than one insurance plan, benefits will be coordinated for reimbursement if you follow the guidelines for your medical plan. At no time should reimbursement exceed 100 percent of charges.

As an active employee, your health insurance coverage is generally considered primary for you. However, should you have other health coverage as the head of contract (not dependent coverage) for yourself, the oldest plan is considered your primary coverage. If covered under a retiree plan and an active plan, the active plan will always be primary. If your spouse has coverage through his or her employer, that coverage would be primary for your spouse and secondary for you.

Primary coverage on children is determined by which parent's birthday comes earliest in the calendar year. The insurance of the parent whose birthday falls last will be considered the secondary plan. This coordination of benefits can be superceded if a court orders a divorced parent to provide primary health insurance coverage.

The health insurance providers have the right to subrogate claims. This means they can recover (1) any payments made as a result of injury or illness caused by the action or fault of another person, or (2) lawsuit settlement from payments made by a third party insurance company. ***This would include automobile or homeowners insurance, whether yours or someone else's.*** You are required to assist in this process.

The plans require an annual verification of other coverage. This information must be returned to your health insurance provider in order to process claims.

On the Job Injuries

The plan will not be responsible for expenses for injuries or illnesses occurring in conjunction with employment.

How Do I Continue Coverage?

You may be able to continue medical (if eligible) and/or dental coverage under the Consolidated Omnibus Budget Reconciliation Act, a federal law referred to as COBRA. This law allows employees and dependents whose medical or dental insurance would otherwise terminate, to continue the same medical or dental benefits for specific periods of time under certain conditions. Covered individuals may continue the medical or dental insurance if *all* of the following conditions are met:

1. Coverage is lost due to one of the “qualifying events” outlined on page 15.
2. Covered individuals are not insured under another group medical plan as an employee or dependent. (This restriction is waived if you or your dependent enroll in another group medical plan that has a pre-existing condition clause, and a condition exists that is not covered by the other plan.) In this situation, you must provide the following to the Division of Insurance Administration:
 - A letter from the new employer or claims administrator explaining that plan’s pre-existing condition clause and how long it applies
 - A letter from your physician stating your pre-existing condition

The Division of Insurance Administration will send a COBRA notification packet to your home at the address on file after being notified there has been a termination of coverage (after all leave has been used) because of one of the qualifying events described below. You or your eligible family member will then have 60 days from the date of the COBRA notification packet to return your application to the Division of Insurance Administration. Coverage will be reinstated immediately if premiums are returned with the application. Please make sure your correct home address is on file with your agency insurance preparer. If you do not receive your notification letter within 30 days after your insurance terminates, you should contact the Division of Insurance Administration.

You or one of your family members must notify the Division of Insurance Administration if a dependent wants to continue coverage under COBRA because:

- Of your divorce from that spouse
- The dependent child is no longer eligible for medical or dental coverage because of a loss of dependent status under the plan (your employer will notify the Division of Insurance Administration of other “qualifying events”)

When one of these two circumstances (divorce or loss of dependent status) occur, you or your dependent has 60 days from the date of the qualifying event or the date the insurance will terminate due to the qualifying event (whichever is later), to notify the Division of Insurance Administration. The Division of Insurance Administration will then send your dependent the COBRA enrollment packet to your address. Restrictions for returning the enrollment form (when premiums must be paid and other provisions) are outlined in the COBRA packet.

There may also be a requirement for you to notify the Division of Insurance Administration in the event of a disability determination by the Social Security Administration. Additional information regarding disability extensions is provided further in this section.

Failure to notify the Division of Insurance Administration within the above prescribed time periods can result in a loss of certain COBRA rights.

How Long Does COBRA Last?

If you qualify for COBRA, the maximum length of time coverage may continue is based on which qualifying event causes your loss of medical coverage.

Qualifying Events for Employees

You may continue your single or family medical coverage for a **maximum of 18 months** if coverage is lost due to one of the following qualifying events:

- Employment is terminated for any reason other than gross misconduct
- Work hours are reduced below 30 hours
- Changes in your job appointment make you ineligible for coverage (example: changing to a temporary position)

Qualifying Events for Dependents

Dependents may also continue their medical or dental coverage under COBRA for **18 months** based on the two events listed for employees. Furthermore, dependents may continue medical or dental coverage for an **additional 18 months**—maximum of 36 months—if coverage is lost due to one of the four qualifying events listed below.

- Your death
- Your divorce from your spouse
- You are eligible for Medicare
- Your dependent child is no longer eligible as a dependent (married, in the armed forces on a full-time basis, over age 24 unless meeting qualifications for incapacitation, etc.)

Medicare – A program administrated by the federal government that provides health benefits for persons age 65 or older and some disabled persons.

A child born to, or placed for adoption with you during a period of COBRA continuation coverage is also eligible for continuation of coverage.

How Much Are COBRA Premiums?

COBRA premiums are equal to 102 percent of the total monthly premium. (Total monthly premium includes employee and employer contributions.) Premiums are not prorated.

When your coverage through COBRA ends, you are eligible to convert to a private, direct-pay plan with your health provider.

If you or your dependents are on an 18-month COBRA extension and were disabled when you originally lost coverage or within 60 days of when you or your dependent's coverage started, you and your dependents may continue coverage for an additional 11 months with an increase (150 percent of the total monthly premium) in payments after the 18th month. In order to qualify, an award letter from the Social Security

Administration (SSA) must be sent by the COBRA participant to the Division of Insurance Administration within 60 days of your receiving SSA's disability letter. You will be notified if the additional 11 months are approved.

When Does COBRA Coverage End?

Any COBRA coverage ends on the earliest of the following:

- The required premium is not paid by the due date
- You or your dependents become insured under another group health plan after the date you elect COBRA coverage under this plan. (However, your COBRA coverage will not be terminated if, on the date you obtained the other coverage, the other group health plan contained a pre-existing condition clause that applies to, or is not otherwise satisfied by, you or your dependent by reason of the provisions of HIPAA. Please contact the Division of Insurance Administration if you believe this applies or you have questions.)
- You or your dependent becomes entitled to Medicare after the date you elect COBRA coverage under this plan
- Coverage has been extended for up to 29 months due to a disability and there has been a final determination during the 11-month extension period that the individual is no longer disabled
- On the last day of the appropriate 18-, 29- or 36-month period

Note: It is your responsibility to share this explanation of COBRA benefits with your covered dependents.

What If I Go on Leave?

Family and Medical Leave Act (FMLA)

FMLA entitles eligible employees to take up to 12 weeks of leave during a 12-month period for an employee's serious illness, the birth or adoption of a child, or caring for a sick spouse, child or parent. If you are on approved family medical leave, you will continue to receive state support of your health insurance premium. Initial approval for family and medical leave is at the discretion of each agency head. Employees must have completed a minimum of 12 consecutive months of employment and worked 1,250 hours in the 12 months immediately preceding the onset of leave.

Leave Without Pay – Insurance Continued

If you choose to continue coverage while on a leave of absence, you will be responsible for the total monthly premium—***employee and employer share***—and will be billed at home each month. The maximum period for a leave of absence is two continuous years. At the conclusion of the two continuous years of leave, you must immediately report back to work for a period of no less than one full calendar month to be eligible for an additional two continuous years of insurance continuation under the leave without pay category. If you do not immediately return to work upon the expiration of two continuous years of leave, coverage is terminated and COBRA eligibility will not apply.

Leave Without Pay – Insurance Canceled

You may cancel coverage while on leave if your premiums are paid current. You may reinstate coverage when you return to work. ***If your coverage is canceled for non-payment, it cannot be reinstated unless you qualify for one of the special enrollment provisions or if you qualify by medical underwriting.***

To Reinstate Coverage After Your Return

Within 31 days of your return to work, you must submit a completed enrollment/change application to your insurance preparer, enrolling in the same health option you had previously. If you do not enroll within 31 days of your return to work, you can only re-enroll by meeting one of the special enrollment provisions or by qualifying through late applicant medical underwriting. The following guidelines apply:

If returning within six months

- No waiting period
- Pre-existing condition does not apply (PPO and POS)

If returning after six months

- Must wait one full calendar month before coverage is effective
- Must satisfy the six-month pre-existing condition clause (page 7) unless employee provides a certificate of coverage letter reflecting other coverage while on leave and there has not been a 63-day lapse (PPO and POS)

If you and your spouse are both insured with the state's group insurance program, you can be covered by your spouse as a dependent during your leave of absence. Any deductibles or out-of-pocket expenses will be transferred to the new contract. Transferring to your spouse's coverage will effect your basic life coverage amounts. After transferring, you will only be eligible for life insurance amounts as a dependent. To transfer coverage, submit an enrollment/change application to cancel your coverage. Your spouse would submit an enrollment/change application to change to family coverage and add you as a dependent. The Division of Insurance Administration must be contacted to coordinate this change and to transfer deductibles and out-of-pocket expenses.

Reinstatement for Military Personnel Returning From Active Service

An employee who returns to the employer's active payroll following active military duty may reinstate insurance coverage on the earliest of the following:

- The first day of the month which includes the date on which the military person was discharged from active duty
- The first of the month following the date of discharge from active duty
- The date on which the military person returns to the employer's active payroll
- The first of the month following the military persons return to the employer's active payroll

If coverage is reinstated before the employee returns to the employer's active payroll, the employee must pay 100 percent of the total premium. In all instances, employees must pay whole month premiums.

Reinstatement of coverage is not automatic. Returning military personnel must re-apply within 90 days from the end of their leave before coverage can be reinstated. No pre-existing condition provision or waiting period requirements will apply.

Leave Due to a Work-Related Injury

Lost-time Pay – Payments received due to lost time (without pay) caused by an approved work-related injury. Lost time pay is approved by the Treasury Department, Division of Claims.

If you experience a work-related injury or illness, contact your insurance preparer about how this will affect your insurance. It is your responsibility to keep insurance premiums current until a notice of lost-time pay has been received from the Division of Claims Administration. Any health insurance payments made by a state employee will be refunded once the notice is received.

If approved for lost-time pay, the premium for **health coverage only** will be paid by your agency. You must pay the premium for any optional coverages on a monthly basis. You are responsible for 100 percent premiums when lost-time pay ends if you do not have any paid leave.

What Can I Expect If I Terminate Employment?

Your insurance coverages will cancel automatically when your agency terminates your employment and this information is provided to the Division of Insurance Administration. You will receive a COBRA notification to continue your health and dental coverages, if eligible, and optional life insurance conversion notices, if applicable, at your home address. **Make sure your correct address is on file with your insurance preparer and payroll/personnel office.**

What If I Retire?

All covered employees who meet the qualifications may continue medical insurance at retirement for themselves and covered eligible dependents. To remain in either a HMO or POS option, you must live in one of the designated service areas or you must change to the PPO option. The retiree, if eligible to continue, must enroll in order to add their dependents. A detailed brochure, *Continuing Insurance At Retirement*, is available from your insurance preparer or by calling the Tennessee Consolidated Retirement System (TCRS) Insurance Section. To continue coverage as a retiree, you must submit an application to continue coverage within one full calendar month from the effective date of your retirement. An individual cannot be classified as a retiree and maintain active coverage as an employee in the same plan.

Retirees and their dependents may retain coverage until they are eligible for Medicare due to age. If a retiree becomes eligible for Medicare Part A prior to age 65, Medicare Part B must be retained to continue coverage. Retirees or covered dependents who are eligible for Medicare by virtue of age will be eligible for a State Medicare Supplemental Plan. The supplemental policy becomes effective on the first of the month following termination of your group insurance. There is no pre-existing condition requirement, waiting period or lapse in coverage. Enrollment material is automatically sent to your home address approximately 90 days prior to your 65th birthday, or you may request enrollment information by calling TCRS.

If enrolled in health coverage, you will receive a letter at your home address approximately 4-6 weeks after active coverage has terminated offering an opportunity to convert your basic life coverage. Premiums for any optional life coverage can only be continued on a direct-pay basis through the carrier (if eligible to continue) and not as

State service – Employment with the State of Tennessee, a higher education institution or a local education agency. Unused sick leave can be counted. Military service that did not interrupt employment or leave of absence cannot be counted toward employment for the purpose of continuing insurance at retirement.

State Employee Qualifications

- Minimum of ten years of state service and covered through the state's group insurance program for three years immediately prior to retirement
- Twenty years of state service and covered through the state's group insurance program for one year immediately prior to retirement
- Must receive a monthly benefit check from the Tennessee Consolidated Retirement System

Higher Education Qualifications

Retirees with an optional retirement plan must meet the service requirements listed below **and** have reached age 55.

- Minimum of ten years of state service and covered through the state's group insurance program for three years immediately prior to retirement
- Twenty years of state service and covered through the state's group insurance program for one year immediately prior to retirement
- No age requirements with 25 years or more of state service and covered through the state's group insurance program for one year immediately prior to retirement
- No monthly benefit for optional retirement plan members is required

a deduction of a TCRS benefit. Dental coverage may continue through COBRA for a specified time period (see pages 14–15).

What If I Don't Qualify?

Retired employees who cannot continue health insurance coverage because of the service requirements previously listed may convert to a private direct payment plan or may be eligible to continue coverage through COBRA. Eligibility requirements for COBRA can be found on pages 14–15. You may be eligible to continue your optional life programs on a direct-bill basis and dental coverage through COBRA.

What Happens to My Medical Insurance If I Become Disabled?

If you become totally and permanently disabled while covered under the PPO medical plan, you (as a former employee) may continue health coverage, for that condition only, for one year at no cost. Coverage is not provided for any other injury or illness and is in lieu of any other option offered by the state group insurance program. You must request this continuation option within one month of your termination date.

If you completed at least five years of service, you may be able to continue health coverage beyond one year if you are determined to be totally and permanently disabled in accordance with the TCRS medical review panel or submission of an award letter from Social Security Administration and are covered under the state group insurance program at the time the disabling injury or illness occurred.

If you remain disabled for a period of two years and become eligible for Medicare Part A and B, you are required to purchase Part B Medicare. Medicare will become primary at this time. Your coverage through the state will become secondary. The state coverage will remain primary for a period of 30 months if diagnosed with end-stage renal disease. You will remain eligible for the state coverage until you become eligible for Medicare due to age.

What Happens to My Covered Dependents If I Die?

If You Are an Active Employee

Your covered dependents may continue health coverage with the state's group insurance program for six months at no cost. After that, they may continue health coverage under COBRA guidelines for a maximum of 36 months as long as they remain eligible. Dental and dependent optional life insurance coverage, if applicable, will terminate at the end of the month of the death of the employee; however, continuation of dental coverage through COBRA will be available. The dependents may be eligible to convert the life insurance to a direct-pay basis.

Line-of-duty – An employee on-the-job in a positive pay status; as determined by the State Division of Claims Administration in the Treasury Department.

If you were a participant in the state plan, your covered dependents may be able to continue health coverage if you had ten or more years of state service. Your designated beneficiary should call TCRS to see if he or she is eligible to receive a retirement benefit.

If You Are a Covered Retiree

Your covered dependents will receive six months of health coverage at no cost. Dependents may continue to be covered as long as they continue to meet eligibility guidelines.

If You Die in the Line of Duty

Your covered dependents will receive six months of health coverage at no cost. After that period, they may continue health coverage only at an active employee rate until they become eligible for other insurance coverage or they no longer meet the dependent eligibility requirements defined on page 8.

If You Are Covered Under COBRA

Your covered dependents will receive six months of health coverage at no cost. After that period, they may continue health coverage under COBRA guidelines if they remain eligible. Coverage may be continued under COBRA for a maximum of 36 months.

How Is Incorrect Information Handled?

Making a false statement on an enrollment or claim form is a serious matter. Only those persons defined by the group insurance program as eligible may be covered. Eligibility requirements for employees and dependents are covered in detail in this book.

If your covered dependent(s) becomes ineligible, it is your responsibility to inform your insurance preparer and complete an enrollment/change application within one full calendar month of that dependent losing eligibility. Once a dependent becomes ineligible for coverage, he/she cannot be covered as a dependent, even if you are under court order to continue to provide coverage.

If there is any kind of error in your coverage or an error affecting the amount of your premium, it is your responsibility to notify your insurance preparer. Any refunds of premiums are limited to three months from the date a notice is received by the Division of Insurance Administration. Claims paid in error for any reason will be recovered from the employee.

Fraud, Waste and Abuse

Financial losses as a result of fraud, waste or abuse have a direct effect on you as a plan member. When fraudulent claims are paid or benefits provided to an individual that is not eligible for coverage, this reflects in the premiums you and your employer pay for the cost of your health care. It is estimated that between 3–14 percent of all paid claims each year are the result of provider or participant fraud. You can help prevent fraud and abuse of the plan by working with us to fight those individuals who engage in fraudulent activities.

How You Can Help

- Pay close attention to the Explanation of Benefits (EOB) forms sent to you when a claim is filed under your contract and always call the toll-free number on the reverse side of your identification card to question any charge that you do not understand — this will prevent providers from billing for services not provided to you or your dependents or misrepresenting the date of service, the amount charged or the type of service provided
- Report anyone who permits a relative or friend to “borrow” his or her insurance identification card
- Report anyone who makes false statements on their insurance enrollment applications
- Report anyone who fabricates claims or alters amounts charged on claim forms

Please contact the Division of Insurance Administration to report fraud, waste or abuse of the plan. All calls are strictly confidential.

Is There an Appeal Process?

Claims Appeal

Before initiating a claims-related appeal, you should first contact the insurance company to get an explanation of the claims payment. If you are unable to resolve your issue, you may then request an appeal.

Appealing to the Insurance Company

Some insurance companies have their own internal appeals process (also known as grievance/complaint procedures) that must be followed prior to appealing to the state. You should refer to your member handbook to determine if this step applies to you. If you are still unsure, you should contact the toll-free customer service number given for your insurance company.

Mental Health and Substance Abuse Appeals

In most instances, mental health claims and medical claims are handled by different companies. To expedite your appeal for mental health and/or substance abuse services, make sure that you appeal directly to the company handling your mental health claims by calling their customer service number. You should complete all levels of appeal through your mental health carrier's appeal process. If your appeal is denied at the final level, you may then appeal to the Division of Insurance Administration.

Appealing to the Plan

This level of appeal is available to you if you have already been through the internal appeals process offered by your insurance company without a satisfactory resolution or if your insurance company does not have an internal appeals process and you have been unable to resolve your issue through their customer service department.

The appeal should be in the form of a letter (from the employee) detailing the events leading to the denial of the insurance claim. Copies of all correspondence and explanation of benefits relating to the claim should accompany the letter. Also include any other documented information, such as names of personnel you have talked with, dates of the communications, physicians' statements, etc. It is very important that you provide a phone number or email address where you can be reached during business hours so that you can be contacted with questions or information about your appeal. The deadline for filing an appeal is two years after claim rejection.

Administrative Appeal

You may also request a review of administrative issues, including certain decisions made on behalf of the plans. To file this type of appeal, provide your agency's insurance preparer with a letter detailing the circumstances of your situation. The insurance preparer will forward your letter to the Division of Insurance Administration. Your correspondence will be reviewed and you will receive a written response to your request.

Appeal Review

When the appeals coordinator in the Division of Insurance Administration receives your information, it will be thoroughly reviewed to determine the exact nature of your appeal. The majority of requests for appeals require additional review by the insurance company. The appeals coordinator will request that the insurance company provide (in writing) the criteria used in making its determination of benefits. The average review takes approximately 30 days to complete. Some cases take longer depending on whether additional information is needed, the response time for the requested information and the complexity of the medical condition.

Some cases may also require review by the state's independent medical consultant. The determination to request such a review will be made by the appeals coordinator.

Many appeals are resolved during this review phase of the process. If, however, your appeal is not resolved, it may be scheduled for presentation to the Staff Review Appeals Committee.

Staff Review Committee

The Staff Review Committee is composed of employees within state government selected by the Insurance Committees. The State Review Committee meets once a month to review appeals that have not been resolved. Prior to the Staff Review Committee meeting, you will be furnished with a copy of your case file and will have the opportunity to notify the Division of Insurance Administration if you feel that any information in the file is incorrect or incomplete. You may make a personal presentation to the Staff Review Committee, or your appeal can be reviewed based on the written record. After the Staff Review Committee has heard your appeal, their votes are tallied and the results are forwarded to the Insurance Appeals Subcommittee.

Insurance Appeals Subcommittee

The Subcommittee consists of selected State Insurance Committee members. This Committee receives a written report of each appeal and is advised of the recommendation from the Staff Review Committee's meeting. After reviewing the written appeals, each Subcommittee member votes individually by written ballot and returns the ballot to the appeals coordinator in the Division of Insurance Administration. If the majority of the Subcommittee votes that they agree with the decision of the Staff Review Committee, the decision will stand. If, however, the majority of the Subcommittee votes for an additional review of the case, it will be scheduled for presentation at a second meeting.

If your appeal is scheduled for a second meeting, you will again be given the opportunity to make a personal presentation. You may make a personal presentation at this level even if you did not appear at the first meeting, or your case can be reviewed on the written record.

You will receive written notification of the outcome of your appeal after all the Subcommittee votes have been returned. It normally takes about two weeks (from the date of the first appeals meeting). The decision of the Subcommittee is final and is the last step in the administrative appeals process.

Pursuing Further Action

If an appeal is denied by both the Staff Review Committee and the Insurance Appeals Subcommittee, state and local education employees may take further action. Along with the notification of the decision on your appeal, you will receive information about contacting the Tennessee Division of Claims in the Treasury Department. Local government employees may take further action through independent legal counsel.

Once you have filed a claim with the Treasury Department, the State Attorney General's Office will be notified of your claim for damages. The following is an outline of guidelines followed by the Attorney General's Office once your claim for money damages is received in their office. Regardless of whether you choose to present your claim at a hearing or by affidavit, you must produce competent evidence in support of your claim. You have the burden of proof.

Hearing

You may request a hearing from the claims commissioner. At the hearing, you will be given the opportunity to present evidence to support your claim for money damages against the state. An assistant attorney general will present evidence to the contrary. The hearing will be conducted like cases in General Sessions Court. Based upon the evidence presented at this hearing, the claims commissioner will rule on your claim.

Affidavit

This is a sworn statement by you and/or any witness in support of your claim. An affidavit must be sworn to before a notary public. If you want to have your claim decided by affidavit without a hearing, you must sign an Agreed Order of Waiver of Hearing. A claims commissioner will sign the order and copies will be sent to you and the undersigned assistant attorney general. When you receive a copy of the order, you should file any affidavits in support of your claim in accordance with the schedule set forth in the order. Once all the affidavits are filed, the claims commissioner will decide the claim based only upon those affidavits.

Employee Assistance Program

The Employee Assistance Program (EAP) is a confidential counseling and referral service for all full-time employees, their dependents and retirees covered under a state-sponsored plan. The EAP can handle problems related to

- emotional
- family
- workplace
- grief
- financial
- mental health
- substance abuse
- legal
- stress
- family/marital
- chronic illness
- elder care

Workshops and seminars are offered to employees on a quarterly basis at nine locations across the state. Others are available upon request.

How Do I Access Services?

All services are strictly confidential and can be accessed by calling the contracted vendor who is available 24 hours a day, 365 days a year. The counselor who takes your call will ask you some questions and refer you to a provider based on the information you provide.

How Much Does It Cost?

You and your eligible dependents may receive up to six counseling sessions per problem episode at no cost. If it is determined that you need greater assistance than through EAP, you will be referred to your insurance provider's mental health and substance abuse benefits. For further questions and information, you may call 615-741-1925.

State Employee Wellness Program

Helping you adopt a healthier lifestyle through information and events that focus on behaviors affecting health and well-being is the business of the State Employee Wellness Program. For more information, you may call 615-741-8675 or 1-800-253-9981.

Babies First Prenatal Program

This program is designed to encourage early prenatal care and provides \$50 and two popular books *What to Expect When You're Expecting* and *What to Expect the First Year*. Registration in the program must occur by the 17th week of pregnancy. Refer to your health provider's member handbook to verify if this benefit is available.

Fitness Center Discounts

Available to all insurance plan members, discount agreements have been secured from over 100 fitness centers throughout the state.

Other Programs and Services

The following benefits are funded through the state's Flexible Benefits Program and are only available to full-time state employees (not higher education or off-line agencies). The major components of the State Employee Wellness Program include awareness, assessment, intervention, referral and evaluation.

Health Screening and Personal Health Analysis

Personal Health Analysis (PHA) provides an evaluation of your current health status and the risks for developing future health problems. All individual results are completely confidential. After completing a questionnaire, you receive personalized results, providing valuable information and resources useful to maintain or improve health and/or well-being. If you are identified as having a health risk, you may receive an invitation to Targeted Intervention Programs (TIPs). You may be eligible to receive confidential, telephone-based assistance from a health educator who will assist in identifying the risk area to target, setting goals and in initiating behavior changes to help modify and improve the targeted high-risk area.

Toll-Free Health Line

Staffed with professional health educators, the HealthLine provides information to assist in making healthy changes. The educators can answer questions, find community resources or information from national organizations, give support and help plan strategies for making healthier choices. The HealthLine can also assist you with registering for a screening, answer questions about your PHA or answer questions on completing the PHA form or understanding your results.

Statewide Seminars and Workshops

At sites across the state, wellness seminars covering a variety of topics including nutrition, exercise and stress are presented. Seminars are announced through payroll inserts and in the *Working Well* newsletter, also distributed via payroll insert.

Video Lending Library

VHS format videotapes covering various wellness topics are available for employees to view. Some of the videos come with a booklet that further explains the subject.

Flexible Benefits Program

The Flexible Benefits Program is administered by the Tennessee Department of Treasury. This program allows full-time state employees (does not include higher education or off-line agencies) to pay health and/or dental insurance premiums before income or social security tax is deducted. Pre-tax premiums reduce an employee's taxable income because they are deducted before taxes are withheld.

How Do I Enroll in This Program?

Enrollment in the Flexible Benefits Program is automatic. However, if you don't want to participate, you may complete a waiver form. This form must be signed and submitted before the end of each year. Detailed information can be obtained through the Department of Treasury by calling 615-741-3131, 8:00–4:30 central time, M–F.

Are There Any Limitations to This Program?

Once enrolled in the Flexible Benefits Program, Internal Revenue Service (IRS) rules do not allow your election to be changed for one year. This means you cannot cancel your coverage during the year, unless you experience a family status change like death, divorce, birth or adoption of a child, or a job change by you or your spouse. You must first have any such event approved through the Department of Treasury. Any change you make must be relative to your family status change.

Does the State Provide Life Insurance?

To be eligible for the various life and special accident insurance programs, you must meet the eligibility guidelines listed on pages 5 (employees) and 8 (dependents). For a newborn to be eligible for basic life coverage, the child must be born alive. For term life coverage, the newborn must remain alive for at least 24 hours.

Basic Group Term Life and Special Accident Insurance

The state provides, at no cost to the employee, \$20,000 of basic term life and \$40,000 of basic special accident coverage for those employees who elect health coverage, earn less than \$15,000 annually and are under age 65. The amount of coverage increases as the employee's salary increases, with premiums for coverage above \$20,000/\$40,000 deducted from the employee's paycheck. The maximum amount of coverage is \$50,000 for term life and \$100,000 for accidental death and dismemberment. The face amount of coverage declines at ages above 65.

Eligible dependents (spouse and children) are covered for \$3,000 of basic dependent term life coverage. Dependents (spouse and children) are eligible for basic special accident insurance, with the amounts of coverage based on salary and family composition.

Optional Special Accident Insurance

This optional coverage is available on a contributory basis for employees and dependents (spouse and children) and is in addition to the basic special accident death coverage. Benefits will be paid for dismemberment if the loss occurs within 90 days of the accident, provided the employee or dependent was covered on the date of the accident and meets the established criteria.

Optional Universal Life and Term Life Insurance Programs

These programs are available on a contributory basis for employees and dependents (spouse and children) whether or not they participate in health coverage. For guaranteed-issue coverage, the employee must enroll during the first full month of employment with the state. If optional life coverage is not elected at that time, the employee may only enroll during the annual enrollment transfer period, and thereby furnishing satisfactory evidence of insurability.

Employees may elect up to three times annual base salary (subject to a maximum of \$300,000) if applying for guaranteed-issue coverage when first eligible. Applicants may apply for up to five times annual base salary (subject to a maximum of \$300,000), but evidence of good health is required for the amounts greater than three times salary. The minimum coverage level is \$5,000 and the employee may choose a combination of universal and/or term life.

Your spouse may have \$5,000, \$10,000 or \$15,000 of universal and/or term life at any age. Spouses below age 55 are eligible for up to one times the employee's annual base salary, subject to an overall maximum of \$30,000. To have guaranteed issue coverage, spouses must be performing normal duties of a healthy person of similar age and gender and not be hospitalized within six months prior to the effective date of coverage. Spouse coverage is available without employee participation.

Children may be covered under either a \$2,500 (for \$0.50 per month) or a \$5,000 (for \$1.00 per month) term rider added to either the employee or spouse contract, but not both. These amounts will cover all eligible dependent children as long as they meet the dependent definition on page 8. If a child is determined to be incapacitated, they may remain covered under the optional life coverage as long as they are eligible.

The Optional Universal Life provides a death benefit, level premiums, a cash value account and policy loan provision. The Optional Term Life provides a lower cost pure death benefit product, but the premiums increase with age. Both optional life products offer advance benefit feature, which makes available part of the life insurance proceeds if an insured encounters a terminal illness.

Dental Insurance

The State of Tennessee offers dental insurance to all eligible employees and their dependents. You must pay 100 percent of the premium if you elect this coverage. Two options are available—a Prepaid Plan and a Preferred Dental Organization (PDO).

In the Prepaid Plan, you must select from a specific group of dentists. Under the Preferred Dental Organization, you may visit the dentist of your choice; however, members receive maximum savings when visiting a PDO network provider. Both dental options have specific guidelines for benefits such as exams and major procedures, and have a three-tier premium structure—single, employee plus one dependent and multi-dependent coverage.

You can enroll in dental coverage as a new employee or during the annual enrollment transfer period. You do not have to be enrolled in health coverage to be eligible for dental insurance. If you are a state employee, please read the Flexible Benefits Program information before canceling dental coverage. Please call your insurance preparer for a brochure, which includes a full schedule of benefits and premiums.

What's the Difference Between the Dental Options?

Prepaid Plan

- No charges for:
 - oral exams
 - routine semiannual cleanings
 - most x-rays
 - fluoride treatments
 - most fillings
- Major services at predetermined copayments
- No claim forms
- Pre-existing conditions are covered
- No maximum benefit levels
- No deductibles

Preferred Dental Organization

- Select any dentist
- \$1,000 calendar year maximum per person
- \$0 calendar year deductible per individual in-network, \$100 per individual out-of-network
- Benefits for covered services paid at the lesser of the dentist charge or the scheduled amount